

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
REGION 19

GROUP HEALTH COOPERATIVE

Employer

and

Case 19-UC-686

OFFICE OF PROFESSIONAL  
EMPLOYEES INTERNATIONAL  
UNION LOCAL 8,

Petitioner

**DECISION AND ORDER CLARIFYING UNIT**

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record<sup>1</sup> in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.
2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.
3. The labor organization involved claims to represent certain employees of the Employer.

**Issue**

Group Health Cooperative (herein "GHC") is a Washington not-for-profit corporation engaged in the operation of health care facilities throughout the State of Washington. Petitioner and its sibling local, Local 23, jointly represent about 900 of GHC's employees employed at its Western Washington locations, in a unit ("Unit")

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<sup>1</sup> Briefs were received from the parties and considered.

composed of a number of different job classifications. The relevant collective bargaining agreement ("Contract") is jointly between GHC and Office and Professional Employees International Union, Locals 8 and 23, AFL-CIO<sup>2</sup>. These Unit employees perform largely business clerical functions, and include positions such as patient care representatives, medical records transcriptionists and claims processors. The Contract's term is from March 16, 1999 through March 15 2002.

Petitioner seeks clarification of the existing unit to include a newly created classification known as durable medical equipment ("DME") coordinator ("DMEC"), arguing that this position is appropriately included in the Unit because these employees perform the same basic functions historically performed by members of the bargaining Unit. Alternatively, Petitioner maintains that the DMECs are an accretion to the Unit. GHC contends that the DME coordinators are not appropriately included in the Unit, because they perform different job functions from those previously performed within the Unit, and because they exercise greater discretion than the Unit positions that formerly performed this work. Additionally, GHC argues that these employees do not share a sufficient community of interest to constitute an accretion to the Unit.<sup>3</sup>

## **Facts**

As described more fully below, DME coordinators are responsible for various functions associated with the processing of referrals and claims for DME. GHC handles the processing of claims and referrals for its Western Washington operations out of a "referral services unit" at two facilities, located in Tukwila and Bellingham. Tukwila is a small city located 10 miles south of downtown Seattle; Bellingham about 90 miles North. The Tukwila operation represents an ultimate consolidation of referral operations that formerly occurred at facilities in Tacoma, Everett, Seattle, Eastside, Bremerton, and Olympia. In 1997, the referral operations of these six facilities were consolidated into two groupings, North and South. In about January of 1999, the two groups were further consolidated into the Tukwila operation. Before the creation of the DMEC position, referral management representatives (RMRs) and network provider representatives (NPRs) were the two classifications whose primary function was the processing of referrals (including referrals of patients to medical specialists) and claims, including DME referrals and claims. The record establishes that there are currently 18 RMRs that work out of GHC's administration building in Tukwila, and 13 NPRs at GHC's facility in Bellingham.

There are some differences between the way that referrals and claims are processed in Tukwila and in Bellingham. The differences are due to the difference in the provider model that is used at the different locations. Tukwila uses a "staff" model,

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<sup>2</sup> Joint representation is shown by the record, as well as by a Stipulation in a recent representation matter involving these same parties.

<sup>3</sup> At hearing, GHC indicated that it would make the argument that the Petition was untimely because Petitioner was aware of the new position for more than six months before filing the UC petition. However, this argument was not raised on brief. In any case, the petition was timely filed because the position in question had not yet been created at the time the current collective bargaining agreement was negotiated. Wallace-Murray Corp., 192 NLRB 1090 (1971).

where the majority of services are provided through GHC (or GHC affiliated) staff clinicians employed at the numerous GHC facilities in the region. Bellingham, in contrast, uses a "network" model, providing members with needed services through non-GHC "network" clinicians, most of whom contract with GHC to provide services for GHC members. GHC and GHC-affiliated clinicians have access to GHC's internal electronic communication system. As a result, most of the referrals to the Tukwila referral services groups are transmitted internally by email, whereas in Bellingham, non-affiliated "network providers" transmit referrals primarily by facsimile or by phone. This difference explains the differing titles of those who have traditionally processed referrals in these locations. In Tukwila, referrals for medical services and DME were processed by individuals called RMRs ("Referral Management Representatives"). In Bellingham, referrals for medical services and DME were processed by individuals called NPRs ("Network Provider Representatives"). These separate titles are still utilized for those not in the new DME group.

In October of 2000, GHC created a new DME group, which included DMECs and a DME supervisor, within the referral services groups at Tukwila and Bellingham. DME consists of such things as hospital beds, power operated vehicles like wheelchairs or scooters, manual wheelchairs, walkers, prosthetic devices, and oxygen equipment. The creation of this new group was motivated at least in part by the signing of a contract in October of 2000 with a single vendor, APRIA, to supply the majority of DME to GHC. This single vendor contract allowed for uniform pricing of the majority of the items that were formerly contracted from a number of different vendors. Initially, six DME coordinators were utilized in Tukwila. Four of these six were hired out of RMR positions.<sup>4</sup> In September of 2001, GHC first utilized a DME coordinator in Bellingham; she was hired out of an NPR position. The record is unclear as to how many full-time equivalent ("FTE") RMRs were dedicated to DME claims and referral work before the DMEC position was created.<sup>5</sup>

The record established the DMEC job functions in detail. The DME coordinator retrieves referrals for DME that have been transmitted from providers' offices. The DMEC is then responsible for determining that a member on whose behalf the referral was made has sufficient coverage for the medical equipment sought, and has met the requisite medical criteria or protocol for receiving the equipment to justify approval of the referral. If needed, the DMEC communicates with the referring provider's office to clarify the appropriateness and completeness of the request. Where high cost items are identified, such as power wheelchairs or prosthetics, the DMEC communicates with the patient or the patient's family to ascertain the specific needs of the patient, and can negotiate with the vendor in an effort to obtain cost saving alternatives, based on the

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<sup>4</sup> No evidence was presented that GHC has since hired new RMRs to fill the open RMR positions.

<sup>5</sup> Susan Anderson, Supervisor of RMRs in the referral services unit in Tukwila, estimated that the DME claims work that was transferred from RMRs to the DME coordinators was .75 FTE. She was uncertain how much of the DME referral work would have been transferred from the RMRs to the DME coordinators, stating, "I can think of two but there could have been four" and adding, "I couldn't tell you for sure, I can't remember". No other evidence establishing the amount of work in FTE terms was presented. She appears to have been referring to individuals doing the work, probably FTEs, but unclear in the record.

patient's needs. The DMEC assists the care provider in choosing the most effective equipment for the particular patient. Where a patient does not meet the clinical criteria for particular equipment ordered, the DME coordinator will refer the case to the Quality Control Review Unit (QCRU) for further review. The DMEC also makes cost effective determinations of rental versus purchase, and repair versus replacement. Additionally, the DMEC coordinates delivery and pick up of the equipment with the patient and the vendor. A few weeks prior to the hearing in this matter, DMECs were given the additional responsibility of processing "suspended claims" for DME.<sup>6</sup>

Dinah Farer, a twenty-five year GHC employee working as an RMR for the past ten years, testified that immediately prior to the creation of the DME group, she worked as an RMR with a DME specialty for two years, in the Unit. The record established that during that time, there were other RMRs who performed the DME specialty work as well. Farer's duties as a DME specialist<sup>7</sup> included retrieving the DME referrals that had been transmitted to the department, and performing all of the necessary steps to process the DME referral. These included ensuring that the patient's benefits covered the equipment, verifying that the patient had met the necessary protocol for receipt of the equipment at issue, communicating with the provider's office if the referral request were incomplete or unclear, identifying orders for high cost equipment, working with provider nurses to achieve the most efficient and cost effective equipment requests, (recommending, for instance, a walker instead of a wheelchair), and referring unresolvable cases to QCRU.

Farer had only limited authority to negotiate with vendors and commit GHC financially, recalling only one instance where she negotiated a price for equipment with a vendor. Farer was responsible for coordinating the retrieval of equipment from patients' homes when it was no longer needed, or communicating with providers' offices if the patient needed to update their "certificate of medical necessity" in order to update the referral. Farer made determinations of renting versus buying equipment for use by patients based on cost effectiveness, and maintained a system for identifying the expiration of referrals for DME. Farer also acted as liaison with DME vendors to help negotiate DME services for patients who did not have DME benefits, usually by getting the GHC price for patients that did not have DME coverage but needed to purchase the equipment themselves. Farer testified that she was not involved in the initial coordination of delivery of DME to patients' homes. Instead, nurses at providers' offices handled this (apparently only in "Seattle", but not Bellingham)<sup>8</sup>. However, she testified that this was not the case at every facility. In Olympia, the RMRs were responsible for this task. Additionally, at another point in her career as an RMR, Farer processed DME reimbursement claims from vendors.

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<sup>6</sup> Suspended claims are those that are not automatically processed due to the absence of a referral that directly correlates with the bill or claim form that is submitted by a provider.

<sup>7</sup> This was an RMR that specialized in DME functions; it was not an official job title.

<sup>8</sup> The nurse transmitted a provider's order for a piece of equipment to the DME Unit personnel, who authorized same. The nurse then arranged the delivery details with the vendor.

In Bellingham, one Unit NPR with a DME specialty handled the DME referrals, until she was hired into the DME coordinator position in September of 2001. No evidence was presented that anyone other than she had handled any of the functions now assigned to the DME coordinators.

Vicky Harrington, currently employed as a non-Unit employee in the referral services group, testified that before 1999, as a Unit member, she handled approximately 20% of the DME referrals, including specifically those that involved "big money" items, such as power wheelchairs and other complex pieces of equipment. At that time, she was a "referral administrator 2", a position that was higher ranking than the RMRs, and was not included in the Unit. She asserts that due to her higher position, she had greater authority to negotiate with vendors and to commit GHC financially than did the RMRs in the DME specialty. She performed these referral functions before the consolidation of operations at Tukwila; her role was limited to those referrals coming into the central Seattle office where she then worked.

At other facilities, including Tacoma<sup>9</sup>, and possibly Everett and Olympia<sup>10</sup>, RMRs were performing the duties that Harrington performed in central Seattle.

In sum, the difference is that "before", the DM function was performed as part of a larger group that handled all manner of referrals, with some individuals specializing in DME matters. "After", these DME functions were moved out to a separate supervisor, largely with the same employees still performing the DME matters, but now called DME Coordinators, instead of RMRs or NPRs. The new work differed from the old in that the DMECs now handled some initial delivery functions that previously were generally (but not exclusively) handled by non-Unit nurses, and the DMEC's had somewhat greater business authority on behalf of GHC. However, to a large extent, authority was seemingly now *more* limited, since for the majority of items there was now a set pricing schedule from a single provider.

## **Analysis**

It is well established that a unit clarification petition is appropriate for resolving ambiguities concerning the unit placement of individuals who come within a newly created classification. *Union Electric Co.*, 217 NLRB 666, 667 (1975); *Bethlehem Steel Corp.* 324 NLRB 241 (1999). When a new classification is performing the same basic functions that a unit classification historically had been performing, the new classification is viewed as remaining in the unit. *Premcor, Inc.*, 333 NLRB No. 164, slip op., P. 2 (2001); *Brockton Taunton Gas Co.* 174 NLRB 969, 971 (1969); *Developmental Disabilities Institute, Inc.*, 334 NLRB No. 143, slip op., P. 3 (2001).

In the instant case, Petitioner maintains that the individuals filling the DME coordinator position have the basic functions that were previously performed by the Unit

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<sup>9</sup> Harrington's testimony.

<sup>10</sup> Testimony of other witnesses.

RMRs and Unit NPRs, including all the essential duties required to process the DME referrals and claims.

GHC, on the other hand, argues that DME coordinators should be excluded from the Unit because they have different job functions from the former DME specialists, involving much greater discretion to negotiate with vendors and to bind GHC in agreements. In defending this position, GHC relies on Harrington's testimony to demonstrate that the DME coordinators' functions were historically performed by non-Unit members. It points also to the fact that at some facilities, non-Unit nurses coordinated the initial delivery of DME to patient's homes.

I find that the DME coordinators are appropriately included in the Unit. The record establishes from January of 1999 until the creation of the DME coordinator position in October of 2000 - apart from the coordination of the initial physical delivery of DME to patients by nurses, and the work performed by the non-Unit "referral administrator 2"(s) - Unit RMR's and NPRs with DME specialties handled all aspects of the DME referral claim work done by GHC. The evidence emphasized by GHC, i.e., the Harrington testimony, is given relatively little weight. The record establishes even when Harrington was involved in DME referral work as a non-Unit "referral administrator 2", the remaining 80% of DME referral work was performed by Unit RMRs. Additionally, Harrington's DME functions as a referral administrator 2 were limited to the former central Seattle facility. The record does not indicate this position existed elsewhere. At other locations, RMRs were handling the very work that Harrington was performing, including referrals involving "big money" items. Further, Harrington moved out of her referral administrator 2 position, into another position, no longer performing the DME function, by the time of the consolidation to the single Seattle (Tukwila) facility, which consolidation took place almost two years before the creation of the new DMEC classification. Thus, her evidence is stale and of limited value, albeit not irrelevant. The record establishes that apart from the coordination by non-Unit nurses of delivery of DME to patients' homes unit, all functions related to DME referral at Tukwila were being performed within the Unit from early 1999 until the creation of the DME group in November of 2000. In Bellingham, an NPR with a DME specialty continued to handle all DME referral work until September of 2001, when the DMEC position was established there.

The fact that non-Unit nurses at the clinicians' offices were generally responsible, pre-change, in Seattle<sup>11</sup>, for coordinating the initial *delivery* of DME to patients' homes, or that DME coordinators now have greater authority to negotiate with vendors, does show that the new job is not precisely identical to the old jobs, and that some new work came from outside the Unit. However, that a new classification may engage in somewhat more discretionary functions than that previously performed by unit personnel does not negate a finding that the new employees are essentially performing bargaining unit work. *Premcor*, supra at slip op. p. 2. See also *Brockton Taunton Gas*

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<sup>11</sup> The nurses did not have this function vis a vis the Bellingham group. There, that particular function apparently had been performed within the Unit all along. Even in at least one location outside Bellingham, this function was performed with the Unit.

Co., supra, holding that enhanced discretion given a new classification, including the right to contract on the employer's behalf, was not of sufficient significance to justify a finding that the new position was not a unit position.

Thus, the record establishes that RMRs and NPRs in Tukwila and Bellingham have historically been responsible for the basic job functions currently performed by DME coordinators. This is clearly the crux, the core, the clear preponderance of the work. In fact, there is little that was not done "before" by at least *some* Unit members somewhere, albeit not always uniformly. Under the cases cited herein, the DME Coordinators appropriately are included in the Unit.<sup>12</sup>

### **ORDER**

**IT IS HEREBY ORDERED** that the petition filed herein be, and hereby is, granted, specifically to include the Durable Medical Equipment Coordinators in the existing Unit.

### **RIGHT TO REQUEST REVIEW**

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street N.W., Washington, D.C. 20570. This request must be received by the Board in Washington by March 12<sup>th</sup> 2002.

**DATED** at Seattle, Washington, this 26th day of February 2002.

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<sup>12</sup> In light of these findings, it is unnecessary to undertake an accretion analysis. See *Premcor*, supra. (Finding that once it is established that a new classification is performing the same basic functions as a unit classification historically had performed, the new classification is properly viewed as remaining in the unit, rather than being added to the unit by accretion. Accordingly, an accretion analysis is inapplicable.)